Short-term Travel

ACE Accidental Dismemberment Claim Form

Adventist Risk Management, Inc.
12501 Old Columbia Pike - Silver Spring, MD 20904
TEL: 1 (888) 951-4ARM (4276) | FAX: (301) 453-7060
EMAIL: claims@adventistrisk.org

How to File a Claim

1. Complete all sections of the attached claim form.
2. Attach the following documents:
    - Medical report from doctor.
    - Medical records.
    - Police report, if applicable.
    - Medical bills relating to the incident.
3. Send the completed and signed claim form and all required documents to:

Adventist Risk Management, Inc.
Claims and Legal Services
12501 Old Columbia Pike, Silver Spring,
MD 20904
Email: claims@adventistrisk.org
Tel: 1 (888) 951-4276 (4ARM)
Fax: (301) 453-7060

4. Retain a copy for your records.

Please familiarize yourself with the summary of benefits provided by your employer. There are provisions, limitations, and exclusions in the policy. ACE Insurance Company makes the final determination on payment or denial of all claims.

A CLAIM ADJUSTER WILL CONTACT YOU IF ADDITIONAL INFORMATION OR DOCUMENTATION IS REQUIRED.

ACE American Insurance Company

Accidental Dismemberment Proof of Loss

POST TO:
Claims & Legal Services
Adventist Risk Management
12501 Old Columbia Pike
Silver Spring, MD 20904
Tel: (301) 453-7400
Fax: (301) 453-7060
E-mail: claims@adventistrisk.org

Name of Group:

Policy Number:

Insured Statement

Name of Insured	Social Security Number	Date of Birth	Telephone Number
Home Address	Employed By		Annual Salary
City	County	Postcode	Occupation

Describe fully your various duties

When did the accident happen? ☐ AM ☐ PM

Where did the accident happen?

How did the accident happen?

What were you doing at the time?

What injury did you receive?

When did you stop working?

Names and addresses of all doctors consulted

Name	Street Address	City, County, Postcode	Date Treated

What operation was performed?

If in a hospital, which one?

From:

To:

Names and addresses of witnesses to your accident

Employer's or Administrator's Statement

Group Policy Number	Certificate Number (If Applicable)	Occupation	Annual Salary
Name of Group Policyholder	Amount of Insurance	Length of Employment From: To:	Insurance Effective Date

Address of Group Policyholder	If Cancelled, Date of Cancellation	Date of Accident	Last Date at Work
Signature of Official Representative		Date Signed	

I authorise any doctor, medical practitioner, hospital, clinic, any other medically-related facility, insurance or reinsuring company, consumer reporting agency, employer, or other entity having information as to the diagnosis, or treatment of any physical or medical condition or treatment or having any nonmedical information pertaining to __ ___ , to give ACE American Insurance Company or its legal representative any and all such information for the purpose of evaluating a claim for benefits.
I understand the information obtained by use of this authorization will be used by ACE American Insurance Company to determine eligibility for benefits un der the policy. Any information obtained will not be released by ACE American Insurance Company to any person or organization except to reinsuring companies, or other persons or organizations performing business or legal services in connection with my claim, or as may be otherwise lawfully required or permitted as I may further authorize.

I know that I may request to receive a copy of this Authorisation.
I agree that a photographic copy of this Authorisation shall be a valid as the original.
I agree this Authorisation shall be valid for two years from the date shown below.
I understand that I may revoke this authorisation at any time by providing the insurance company with written notification as to my intent to revoke.

Signature of Insured or Authorised Representative	Dated

Address:

Fraud Warning: "It is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or any other person. Penalties include imprisonment and /or fines. In addition, an insurer may deny insurance benefits if false information materially related to a claim was provided by the applicant."

Attending Doctor's Statement

Patient's Name	Date of Birth

Patient's Address (Number and Street, County, Postcode)

Diagnosis:

If loss is sight, is loss in both eyes? ☐ Yes ☐ No

Is loss total and irrecoverable? ☐ Yes ☐ No

If no, visual acuity at this time:

If loss is hearing, is loss in both ears? ☐ Yes ☐ No

Is loss total and irrecoverable? ☐ Yes ☐ No

If no, hearing at this time:

If loss is speech, is loss total and irreversible? ☐ Yes ☐ No

If no, speech at this time:

If loss is extremity, where is severance?

In your opinion, was the loss caused by an accident independent of all other causes? ☐ Yes ☐ No

In your opinion was the loss caused in any way by illness? ☐ Yes ☐ No

If yes, list dates you provided treatment for this illness: _____; _____; _____

Please give an account of the accident as you understand it happened:

Dates of treatment for this accident:	(Day, Month,Year)	(Day, Month,Year)	(Day, Month,Year)	(Day, Month,Year)

To your knowledge, has the patient ever been treated for this same condition? ☐ Yes ☐ No

If yes, please explain:

Remarks:

Name (Attending Physician) – Please Print	Degree/Professional Designation	Telephone Number

Doctor's Address (Number and Street, County, Postcode

Signature	Date

Fraud Warning: Certain states require specific state mandated fraud language to be included on all claims forms while other states use a generalised fraud stated. ACE USA Accident &Health has adopted the fraud warning language prescribed by the District of Columbia as its standard fraud statement. Unless otherwise noted below this statement shall be included on all claims forms, applications an d enrolment forms.

District of Columbia Generic Warning:
It is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or any other person. Penalties include imprisonment and / or fines. In addition, an insurer may deny insurance benefits if false information materially related to a claim was provided by the applicant.

The following states have required us to use state specific language as follows:
California
For your protection California law requires the following to appear on this form:
Any person who knowingly presents false or fraudulent claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

Colorado
It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance and civil damages.

Florida
Any person who knowingly and with intent in injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree.

New York
Any person who knowingly and with to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact thereto, commits a fraudulent insurance act, which is a crime and shall also be subject to a civil penalty not to exceed $5,000 and the stated value of the claim for each such violation.

Oklahoma
WARNING: Any person who knowingly, and with intent to injure, defraud or deceive any insurer, makes ant claim for the process of an insurance policy containing any false, incomplete or misleading information is guilty of a felony.

Pennsylvania:
Any person who knowingly and with intent to defraud any insurance company or other person files a statement of claim containi ng any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

Maryland/Oregon
Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer submits an application or files a claim containing a false or deceptive statement may be guilty of insurance fraud.

Virginia
Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer submits an application or files a claim containing a false or deceptive statement may have violated state law.